First Health Services of Montana
PARTIAL HOSPITAL CARE
Continued Stay Request Form

First Health Services of Montana
To transmit request information:
FAX: 1-800-639-8982
PHONE: 1-800-770-3084

Mail: 4300 Cox Road
Glen Allen, VA 23060

Partial Hospital Care Continued Stay: **Youth Acute** ☐ **Adult Acute** ☐
Youth Sub-Acute ☐

Please print or type:

PATIENT INFORMATION	
Patient Name:	
Medicaid Number:	**SSN:**
MHSP Number:	
FACILITY INFORMATION	
Name:	**Provider Number:**
Address:	
City:	**State:** **Zip Code:**
Telephone Number:	**Fax Number:**
Number of Days Requested:	**Start Date:**
CLINICAL INFORMATION	
Any Changes in DSM-IV DIAGNOSIS:	
Code:	**Narrative:**
Code:	**Narrative:**
Current Mental Status:	
Justification for continued services at this level of care (To include behavior on unit):	

Processing may be delayed if information submitted is <u>illegible</u> or <u>incomplete</u>

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Name Last: _____ First: _____
SSN: _____

Current Medication (include dosage and start date):
Treatment Plan/Goals:
Scheduled Activities/Groups (describe participation):
Case Management:
Does patient have a case manager? Yes No
Case manager name:
Case management company:
Discharge Plan (please include estimated date of discharge):
Assessment completed by:
Title: Date:

For First Health's Use Only:
APPROVED**:** From_____ Thru_____ DENIED: From_____ Thru_____
Review Date:_____ Reviewer Signature: _____

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